

***South Dakota Department of Health  
Tobacco Control Program  
Strategic Plan***

***November 2005***

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# Overview of Tobacco Use in South Dakota

November 2005

- Tobacco use is the single most preventable cause of death and disease—responsible for the death of more than 1,000 people in this state each year.<sup>1</sup>
- Tobacco use kills more people each year than alcohol, HIV, car crashes, illegal drugs, murders, & suicide **combined**.<sup>2</sup>
- The adult smoking rate in South Dakota has decreased to 20.3% (2004 BRFSS) from a peak of 27.2% in 1998.<sup>9</sup>
- In 2003, 71% of high school students and 51% of middle school students reported exposure to secondhand smoke.<sup>3</sup>
- Tobacco use is responsible for over \$1,600 per smoker in excess medical expenditures each year.<sup>4</sup>

**The following have been identified as populations with disparate tobacco use in South Dakota.**

## Youth

Over 80% of adult tobacco users started using tobacco before the age of 18. During the 1990's, smoking among South Dakota youth increased.<sup>5</sup> In 1999, 44.0% of our high school youth smoked. The latest Youth Risk Behavior Survey (2003 YRBS) reports 30% of high school youth are current smokers, down from 33% in the 2001 report, while 15% report spit tobacco use, which is unchanged since the 2001 survey. The 2003 Youth Tobacco Survey (YTS) shows that 6% of middle school youth smoke and 2% reported using spit tobacco, down from 12% and 8% respectively in 2001.

## Young Adults

Statistics for young adults, 18-24 years of age, show a decrease in smoking from 2003 to 2004. The SD Behavior Risk Factor Surveillance System (BRFSS) data from 2003 showed 34% of 18 -24 year olds smoked. Preliminary data from the 2004 SD BRFSS shows 26% of this age group smoke. The most recent data (from 2003) shows that 17% of males this age used spit tobacco either some days or everyday.

## Non-ceremonial Tobacco Use by American Indians

The BRFSS data over the past several years shows the following cigarette smoking rates among American Indians: 41% in 2000, 52% in 2001, 39% in 2002, and 53% in 2003. The preliminary data for 2004 indicates that 47% of adult American Indians in South Dakota smoke.

The 2003 YTS was stratified to provide data about commercial tobacco use by American Indian youth. The data show 26% of middle school youth and 53% of high school youth reported smoking, and 5% of middle school youth and 28% of high school youth used spit tobacco during the 30 days prior to the survey.

## Pregnant Females

BRFSS shows a small but steady decline in the overall number of pregnant females that use some form of tobacco. In 1993, tobacco use by pregnant females was 20% for whites and 42% for American Indians. In 2002, tobacco use by pregnant females was 18% for whites and 27% for American Indians.<sup>6</sup>

## Medicaid Clients

According to the Centers for Disease Control & Prevention, smoking rates are highest among people with low incomes, and the negative health effects of tobacco use are of major concern for State Medicaid programs. Medicaid recipients have approximately 50% greater smoking prevalence than the overall U.S. population. In 2000, approximately 11.5 million (36%) adult Medicaid recipients smoked cigarettes.<sup>7</sup> According to a 2005 survey of low income clients served by the Department of Social Services, 36% are current smokers; just over 26% smoke everyday and 9% smoke some days.<sup>8</sup>

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<sup>1</sup>Centers for Disease Control and Prevention. *Smoking-Attributable Mortality (South Dakota, 2001)*. Retrieved October 2004 from:  
[http://apps.nccd.cdc.gov/sammec/sam\\_reports.asp?data\\_element\\_year=2001&data\\_element\\_state=SD&quick\\_state\\_pick=Go](http://apps.nccd.cdc.gov/sammec/sam_reports.asp?data_element_year=2001&data_element_state=SD&quick_state_pick=Go)

<sup>2</sup>Centers for Disease Control and Prevention. (Updated February 2004) *Tobacco Related Mortality Fact Sheet*. Retrieved March 2004, from:  
[http://www.cdc.gov/tobacco/factsheets/Tobacco\\_Related\\_Mortalityfactsheet.htm](http://www.cdc.gov/tobacco/factsheets/Tobacco_Related_Mortalityfactsheet.htm)

<sup>3</sup>South Dakota Department of Health. *South Dakota 2003 Youth Tobacco Survey*.

<sup>4</sup>Centers for Disease Control and Prevention. *Morbidity and Mortality Weekly Report* 2002; 51(14):300–303. (PDF) Retrieved: March 2004 from: <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5114a2.htm>

<sup>5</sup>South Dakota Department of Education. *South Dakota Youth Risk Behavior Trend Data 1991- 2001*. Retrieved: March 2004 from:  
<http://www.state.sd.us/deca/CSCF/schoolhealth/yrbs/2002/YouthRiskManual.pdf>

<sup>6</sup>South Dakota Department of Health, Vital Records birth certificate data.

<sup>7</sup>Centers for Disease Control and Prevention. *Morbidity and Mortality Weekly Report* 2004; 53 (3): 54-57. (PDF) Retrieved April 16, 2004 from: <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5303a3.htm>

<sup>8</sup>South Dakota Department of Health with data compilation and analysis by the Business Research Bureau and Stuefen Research, LLC. *South Dakota Tobacco Use Study of the Population Served by Social Services*. 2005.

<sup>9</sup>South Dakota Department of Health, Behavior Risk Factor Surveillance System, 2004 data.

## Introduction

The Department of Health (DOH) is the lead agency for the statewide management of tobacco use prevention and cessation. The South Dakota Tobacco Control Program (TCP) efforts are based on those practices shown to be successful and recommended in *Best Practices for Comprehensive Tobacco Control Programs* compiled by The Centers for Disease Control and Prevention (CDC) and at the local level.

The TCP, along with an advisory committee of diverse individuals with expertise and interest in tobacco prevention, developed this strategic plan, during the spring of 2004, and update the plan annually. The strategies, goals, and objectives reflect evidence-based approaches for reducing the number of people that start using tobacco, reducing the number of people exposed to secondhand smoke, and increasing the number of people that quit using tobacco. While the program goals are intended to address tobacco use for all populations, special emphasis is placed on those populations with disparate tobacco use. The instruments used to determine tobacco-related disparities are listed throughout this plan and in the resource section at the end of the plan.

Members of the advisory committee reviewed information from documents such as *Best Practices for Comprehensive Tobacco Control Programs*, by the Centers for Disease Control and Prevention; *The Guide to Community Preventive Services: Tobacco Use Prevention and Control*, by the Task Force on Community Preventive Services, as well as data collected in the state pertaining to tobacco use.

## Guiding Principles

The guiding principles agreed upon by the tobacco prevention advisory committee and listed below form the foundation for tobacco - prevention strategic planning and program implementation in South Dakota. These principles serve as a reference point for decision-making, and are based on the following nine components of comprehensive tobacco control, recommended by the CDC:

- 1) Community programming
- 2) Linkage to chronic disease programs
- 3) School programming
- 4) Linkage to enforcement of tobacco control policies
- 5) Statewide programming
- 6) Counter-marketing
- 7) Cessation programming
- 8) Surveillance and Evaluation
- 9) Administration & management

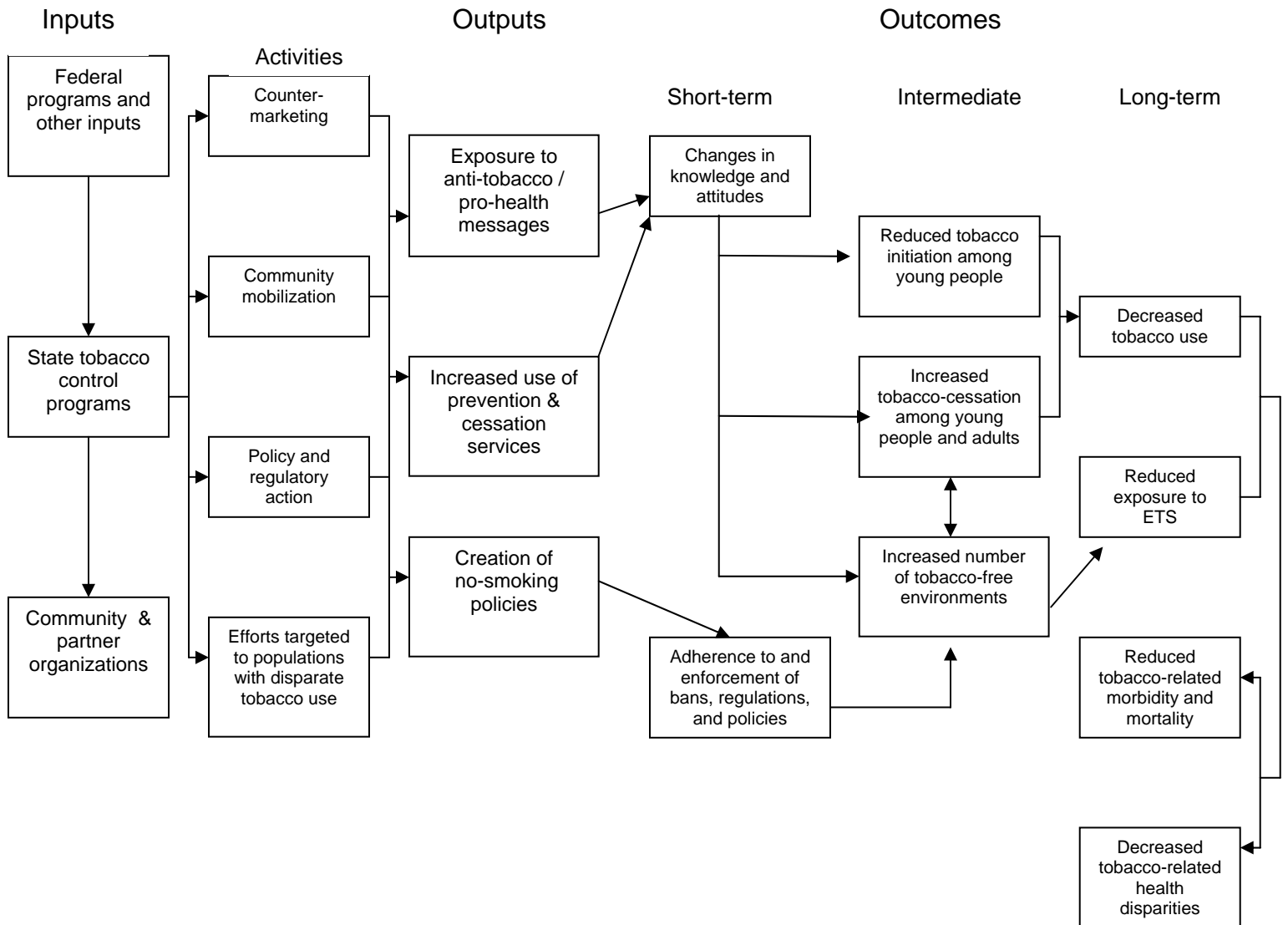
- **Best practices, evidence-based strategies:** Provide vigilance regarding the use of evidence-based approaches to assure that intended results are achieved.
- **Sustainability and replication:** Support efforts that can be sustained and replicated, to enhance the ability to expand efforts across the state.
- **Measurement and accountability:** Support measurement and accountability practices that will evaluate impact and outcomes.
- **Conflict of interest:** Assure individuals, organizations and contractors have no conflict of interest regarding funding from or ties with the tobacco industry.
- **Population-based, Systems Approach:** Support, whenever possible, a systems approach to comprehensive tobacco use prevention that is population-based.
- **Collaboration and coordination:** Promote coordination and collaboration of efforts by tobacco prevention advocates.
- **Disparate use of tobacco Use:** Identify and eliminate disparities related to tobacco use.

## **Logic Model Rationale**

The Centers for Disease Control and Prevention, Office on Smoking and Health (OSH) provides funding and technical assistance to the South Dakota Department of Health to reduce tobacco-related disease and death. In addition, OSH has developed logic models for major goal areas. The models are designed to display the relationship between tobacco prevention resources, activities, and program outcomes. One purpose of the models is to help stakeholders link prevention efforts planned to intended outcomes, to help ensure that actions taken will result in desired outcomes and goal achievement. Logic models also include “indicators” – specific, measurable characteristics that show the progress being made toward achieving a specific outcome and goal.

The logic models are included in this plan to visually summarize the actions and goals of the program, as well as identify indicators for progress. Below is an overview model, and preceding each goal area are models specific to each of the major goals for the South Dakota Tobacco Control Program.

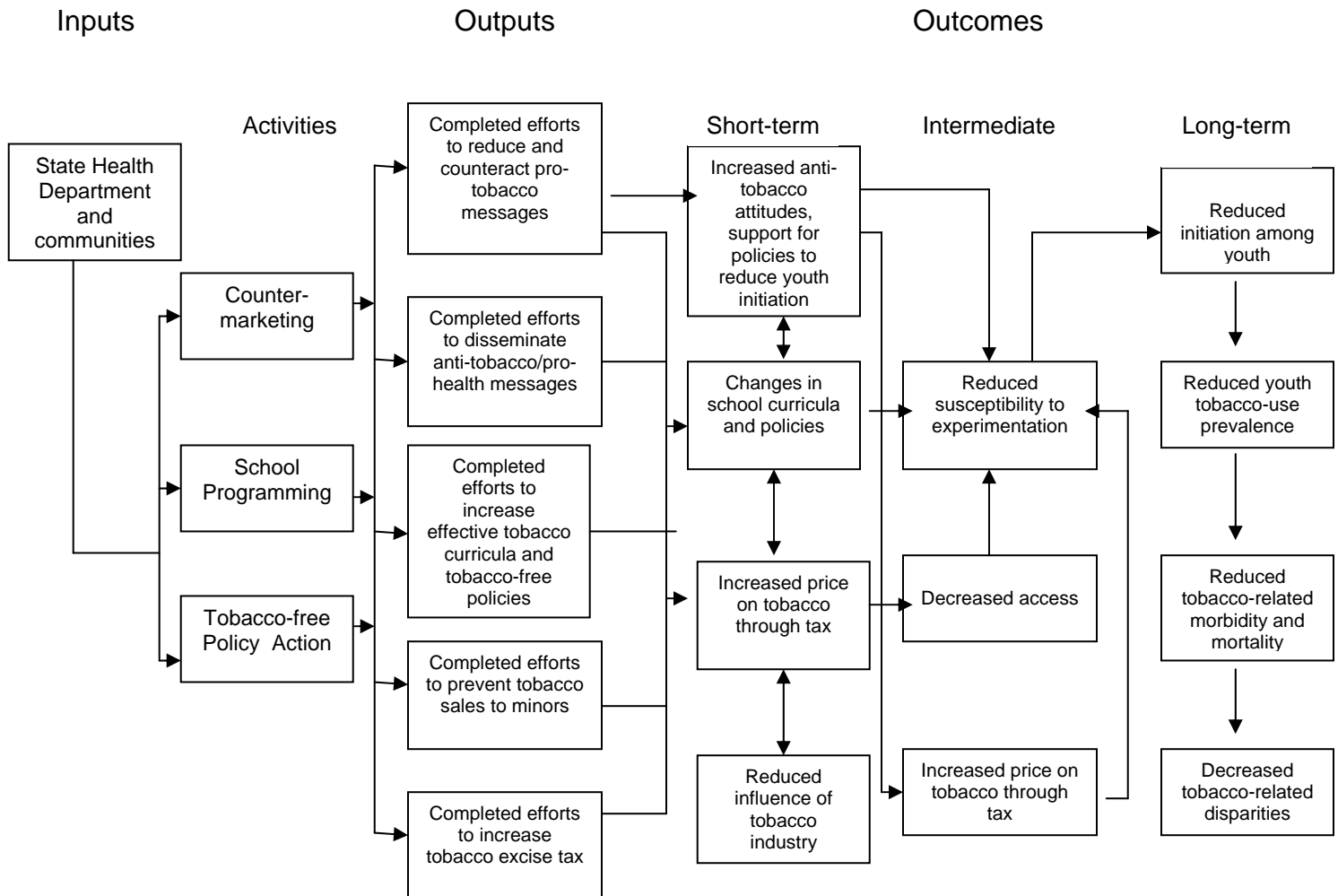
## TOBACCO-USE PREVENTION AND CONTROL LOGIC MODEL





## Goal One:

### PREVENTING INITIATION OF TOBACCO USE AMONG YOUNG PEOPLE



**Strategies:** Increase pro-health knowledge and counter marketing efforts that discourage youth tobacco use, and inform communities of effective, evidenced-based prevention endeavors.

#### Evidence:

Media programs that target youth are effective in reducing tobacco use among adolescents, as reported by the Task Force on Community Preventive Services in the February 2001 Supplement to the American Journal of Preventive Medicine and a study reported in the July 2005 journal, Archives of Pediatrics & Adolescent Medicine.

The report also indicates that the influence of counter-marketing media is more effective when combined with other prevention efforts. Because youth spend much of their formative years in school being influenced by curriculum as well as peers, it is logical and supported by evidence that educational programs including social consequences of smoking are effective in reducing youth tobacco use.

(U.S. Department of Health and Human Services. Preventing Tobacco Use Among Young People. Public Health Service Ed. Washington DC: Surgeon General's Report 1994.)

In addition to using tobacco prevention curriculum in schools, youth-led prevention education allows youth to be involved in community efforts as well as providing positive role-modeling for others. According to the American Lung Association, a peer-teaching model is supported by studies such as the one reported in the March 1998 Journal of School Health on the effectiveness of peer education in reducing alcohol, tobacco, and other drugs use among youth.

Such peer involvement and communication are based on face-to-face education and activities including role-playing, which provide real world, age-appropriate experiences.

Based on this evidence the following objectives and actions are planned to reduce the number of youth that start using tobacco.

### **Objectives:**

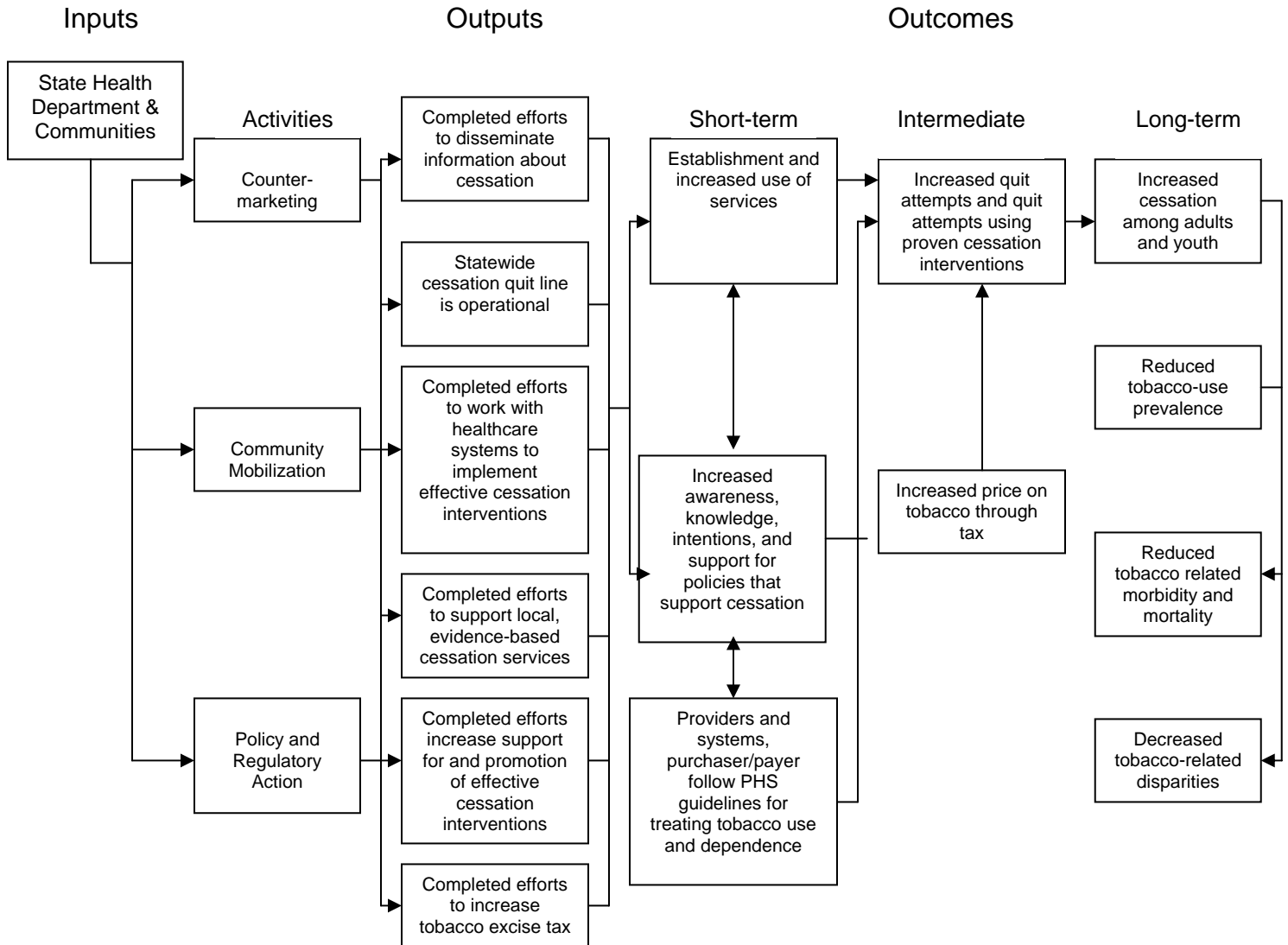
1. By 2008, increase the percentage of middle school students who report seeing/hearing an anti-tobacco message from 72% to 80 % (2003 YTS).
2. By 2008, increase the number of middle school students & high students that report receiving anti-tobacco education from 29% (2003 YTS) to 33%.
3. By 2008, reduce the number of young people ages 18 -24 who smoke from 26% (2004 BRFSS) to 22%.

### **Actions:**

1. Encourage and assist school staff, parents, and students to support and adopt a written 100% tobacco-free policy for school campuses and school sponsored activities.
2. Assist communities to obtain and post signage designating tobacco-free status.
3. Encourage schools to decline contributions offered to school-related organizations and activities that come from organizations that promote the use of tobacco.
4. Support credible training for youth-led tobacco prevention education, such as the American Lung Association's Teens Against Tobacco Use (T.A.T.U.).
5. Assist communities and schools to educate youth about the media aimed at promoting youth and teen use of tobacco.
6. Conduct public education campaigns that will counter promotion of tobacco use, and promote pro-health messages to youth and young adults
7. Provide information and assistance to develop advocates for reduced tobacco promotional events targeting youth and college-aged people.
8. Encourage and assist communities and schools to use effective tobacco-prevention curricula, along with other effective prevention strategies in their community.
9. Promote infusion of prevention lessons into existing, core subject areas correlating the lessons to the state core content standards so educators understand these are not "extra" lessons.
10. Share effective prevention strategies for college-campus with staff and student leadership at post-secondary campuses.
11. Distribute fact sheets on effective, evidenced-based strategies recommended by the Task Force on Community Preventive Services.

## Goal Two:

### PROMOTING TOBACCO CESSATION AMONG ADULTS AND YOUTH



**Strategies:** Promote evidenced-based tobacco cessation efforts, including but not limited to the statewide, telephone-based quit line, and increase effective cessation advice by health care providers.

## Evidence:

Telephone cessation services are effective in increasing tobacco use cessation when combined with other interventions including educational materials and medication. In addition, mass media campaigns are effective in increasing the cessation in adult tobacco users. Clinicians and health care delivery systems can increase the number of people that quit using tobacco, using even brief advice, and systems changes are important in accomplishing this.

## Objectives:

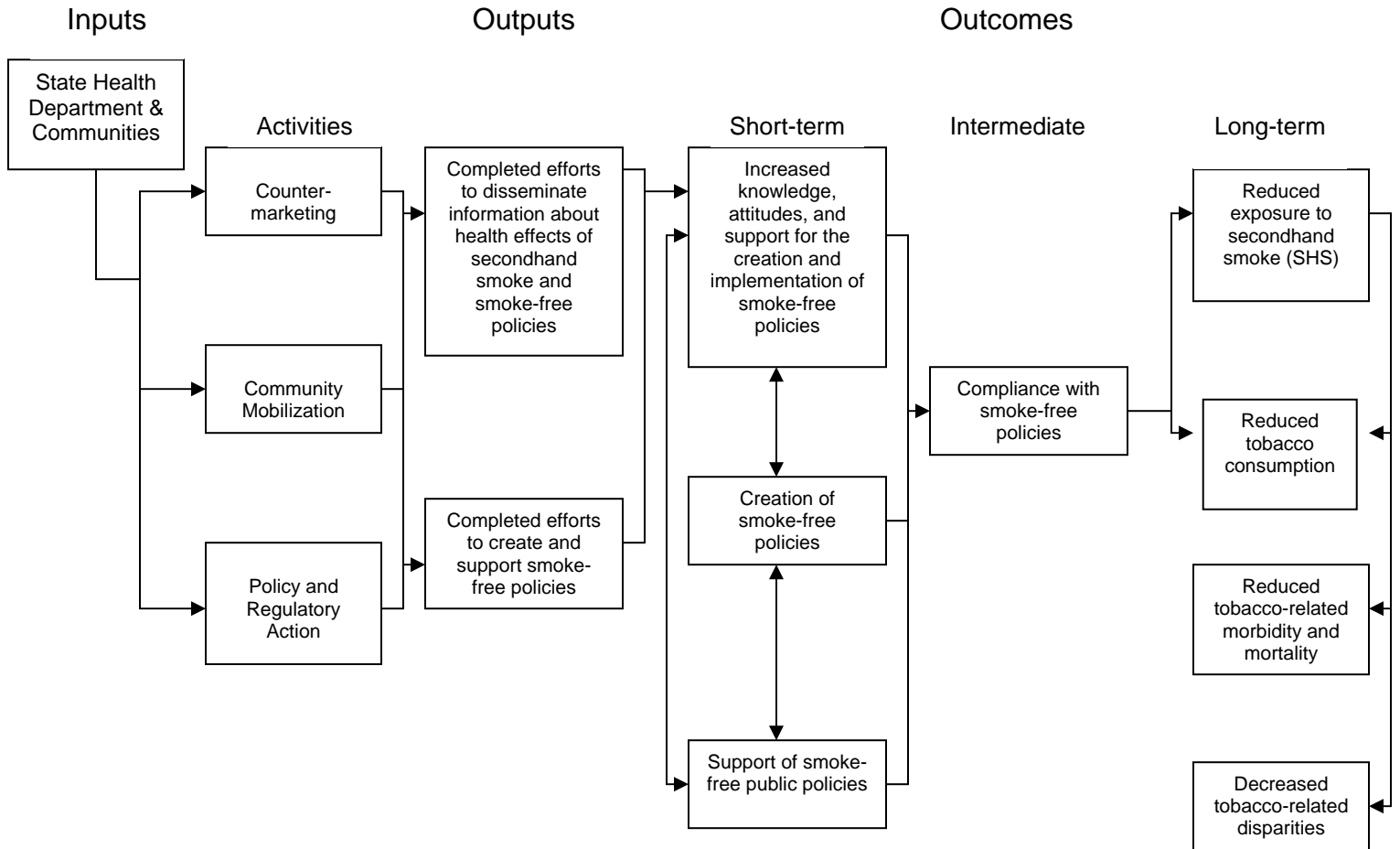
1. By 2008, average at least 230 calls per month to the South Dakota Quit Line (QL).
2. By 2008, average at least 25% of referrals from health care providers to the QL.
3. By 2008, provide information about the benefits of implementing the Public Health Service guidelines for Treating Tobacco Use and Dependence to least 4 health care facilities and/or health plans.
4. By 2008, increase from 66% (2003 BRFSS) to 80 % the percentage of adult tobacco users who report being advised by their health care provider to quit.
5. By 2008, reduce the number of pregnant females that smoke from 19% to 13%.
6. Increase the number of current smokers aged 18 and older who have quit smoking for at least 1 day from 58% (2002 BRFSS) to 60%, by 2008.
7. Increase the number of current smokers grades 9 -12 who have quit smoking for at least 1 day from 50% (2003 YTS) to 55%, by 2008.
8. Reduce the number of adults that currently smoke from 20% (2004 BRFSS) to 18%, by 2008.
9. Reduce the number of American Indian adults that currently smoke from 47% (2004 BRFSS) to 33% by 2008.
10. Reduce the number of adults that currently use spit tobacco everyday from 7% (2004 BRFSS) to 5%, by 2008.
11. Reduce the number of youth grades 9 -12 that currently use spit tobacco from 15% (2003 YRBS) to 8%, by 2008.
12. Prevent an increase in the number of middle school youth that currently use spit tobacco, through 2008, (2% per the 2003 YTS).
13. Reduce the number of youth grades 9 -12 that currently smoke from 30% (2003 YRBS) to 27%, by 2008.
14. Reduce the number of middle school youth that currently smoke from 6% (2003 YTS) to 5%, by 2008.

## Actions:

1. Promote the statewide Quit Line by providing referral materials to local coalitions, local public health offices, private health care providers, hospitals, and health plans.
2. Provide information about the Public Health Service guidelines for Treating Tobacco Use and Dependence to health care providers and organizations.
3. Assist local communities in promoting the QL and other credible cessation services to tobacco users.
4. Review success of projects around the state and the nation designed specifically to assist youth to quit using tobacco, and promote those with evidence of success.
5. Collaborate with schools providing health education to health professionals so as to increase tobacco cessation and prevention education.
6. Assist health care organizations to adopt “best practices” service delivery systems that include screening for tobacco use, as well as advice and support to quit.
7. Assist college campuses and other places serving populations of those aged 18 – 24 in promoting and providing cessation services.
8. Collaborate with other state agencies, such as Medicaid to promote cost-saving measures such as using the quit line and promoting providers’ cessation advice to clients.

### Goal Three:

#### ELIMINATING NONSMOKERS' EXPOSURE TO SECONDHAND SMOKE



**Strategies:** Increase awareness of the health and economic costs of exposure to secondhand smoke and increase support for policies that create tobacco-free environments

### Evidence:

Secondhand smoke in restaurants is higher than offices, and levels in bars are much greater than either restaurants or offices. According to a report by the U.S. Surgeon General, the primary source of adults' exposure to secondhand smoke occurs in the workplace and the home. Morbidity and mortality due to secondhand smoke is well documented. Increasing awareness of the health and economic effects of exposure to secondhand smoke is the first step to increasing smoke-free policies, which is a strategy with strong evidence of reducing non-smokers' exposure to this toxin.

**Objectives:**

1. By 2008, reduce the number of youth grades 9 -12 that were in the same room or car as someone smoking, from 71% to 67%. (2003 YTS)
2. By 2008, reduce the number of youth grades 6 - 8 that were in the same room or car as someone smoking, from 51% to 47%. (2001 YTS)
3. By 2008, increase the number of adults that report smoking is not allowed in any public areas from 79% to 85%. (2001 BRFSS).

**Actions:**

1. Provide public education regarding the health and economic effects of exposure to SHS to parents, business owners, policy makers, and the general public.
2. Provide communities and businesses with information about the benefits of tobacco-free policies.
3. Provide public education regarding the public support for tobacco-free policies.
4. Produce and provide tobacco-free business kits to communities, coalitions, healthcare providers, businesses, and other organizations interested in the assistance.

## **Linkages to Chronic Disease Programs**

In the South Dakota Department of Health, the Tobacco Control Program is located in the Office of Health Promotion, along with the Cancer Registry, Cardiovascular Health, Chronic Disease – Breast & Cervical Cancer Control & Screening programs, Coordinated School Health, Diabetes Control, and Oral Health programs.

Because these programs are within the same office and report to the same administrator, programs work closely together. This increases the ability for coordinated efforts and exchange of information. Numerous projects are conducted across program lines. For example, in the *All Women Count!* - Breast & Cervical Cancer Control & Screening programs, staff worked together to include the Public Health Service (PHS) Guidelines for Treating Tobacco Use and Dependence as part of the service delivery algorithm. Training has been provided to over 150 health care provider facilities across the state, and referral materials for the South Dakota Quit Line were also distributed. Staff are now working on a clinic-based tobacco cessation model to be promoted to more healthcare facilities across the state.

In addition to working closely with the programs mentioned, the Tobacco Control Program also coordinates efforts with other programs and departments within state government serving people with chronic disease. Some examples are Medicaid, Maternal Child Health programs, and Community Health Services.

## **Strategic Plan Resources**

**South Dakota Youth Tobacco Survey / The South Dakota Youth Risk Behavior Survey** - Paper and pencil surveys of randomly selected middle and high school students in South Dakota, conducted in odd-numbered years. The Youth Tobacco Survey will assess middle school youth while the Youth Risk Behavior Survey will assess high school students.

**South Dakota Adult Tobacco Survey/The Health Behaviors of South Dakotans** -Telephone surveys of randomly selected adults over the age of 18. The Health Behaviors of South Dakotans report is derived from the Behavior Risk Factor Surveillance System data conducted annually. The Adult Tobacco Survey was conducted in 2002 and 2004 in South Dakota.

**The South Dakota School Health Education Profile** - Paper and pencil survey of elementary principals and teachers in South Dakota, assessing the status health education curriculum content, coordination, instructional techniques as well as perceptions of the importance of such curriculum. The most recently published report was conducted in 2002.

**The South Dakota Department of Health, Office of Vital Records** - Data provided by this office includes smoking during pregnancy information collected on birth certificates; collected annually.

**South Dakota Tobacco Use Study of the Population Served by Social Services** – Paper and pencil survey conducted in 2005 with a response from over 9,000 low income clients served by the South Dakota Department of Social Services. Data compilation and analysis by the USD Business Research Bureau and Stuefen Research, LLC.